Reset Form

APPLICATION FOR PROVIDER CERTIFICATION
AGED AND DISABLED WAIVER (A&D)
TRAUMATIC BRAIN INJURY WAIVER (TBI)

State Form 55512 (R / 7-14)

Attention: Waiver / Provider Analyst
FAMILY AND SOCIAL SERVICES ADMINISTRATION
INDIANA HEALTH COVERAGE PROGRAMS (IHCP)
DA Home and Community-Based Services Waivers
402 West Washington Street, Room W382, MS 07
P.O. Box 7083
Indianapolis, IN 46207-7083

INSTRUCTIONS:
1. *Mail the completed, signed and dated documents to the FSSA Division of Aging at the above address, or e-mail them to daproviderapp@fssa.in.gov.*
2. *Retain copies of all documents mailed to the FSSA Division of Aging.*
3. *If you have any questions regarding the completion of the packet, please visit the website at http://www.in.gov/fssa/da/3476.htm or contact a waiver provider specialist in the FSSA Division of Aging at (317) 232-4650 or e-mail daproviderapp@fssa.in.gov.*

Date of application *(month, day, year)*

Type of application *(check one)*
☐ New application ☐ Change of ownership ☐ Add service(s)

Name of applicant

Telephone number ( )

Fax number ( )

E-mail address

Legal business name of applicant

Doing business as (DBA) name of applicant

Legal status of provider *(check one)*
☐ Individual / sole proprietor ☐ Corporation ☐ Partnership

Indiana State Department of Health (ISDH) license number

Name license issued to

Name of Chief Executive Officer (CEO) / administrator / owner

Name of contact person

Title

Physical location *(number and street, city, state, and ZIP code)*

Mailing address *(if different from above) (number and street or Post Office box, city, state, and ZIP code)*

Type of waiver in which you wish to provide services *(check all that apply)*
☐ Aged and Disabled (A&D) *(** only)* ☐ Traumatic Brain Injury (TBI) *(* only)*

Service(s) you plan to provide *(check all that apply)*

☐ Adult Day Services	☐ Environmental Modifications	☐ Specialized Medical Equipment and Supplies
☐ Adult Family Care	☐ Healthcare Coordination	☐ Structured Day Program*
☐ Assisted Living	☐ Home Delivered Meals	☐ Structured Family Caregiving**
☐ Attendant Care	☐ Homemaker	☐ Supported Employment*
☐ Behavior Management*	☐ Personal Emergency Response System	☐ Transportation
☐ Case Management	☐ Residential Based Habilitation*	☐ Vehicle Modifications
☐ Environment Modification Assessment**	☐ Respite	

County(ies) in which you plan to provide service(s) *(check all that apply)*

☐ 01 Adams	☐ 15 Dearborn	☐ 29 Hamilton	☐ 43 Kosciusko	☐ 57 Noble	☐ 71 St. Joseph	☐ 85 Wabash
☐ 02 Allen	☐ 16 Decatur	☐ 30 Hancock	☐ 44 LaGrange	☐ 58 Ohio	☐ 72 Scott	☐ 86 Warren
☐ 03 Bartholomew	☐ 17 DeKalb	☐ 31 Harrison	☐ 45 Lake	☐ 59 Orange	☐ 73 Shelby	☐ 87 Warrick
☐ 04 Benton	☐ 18 Delaware	☐ 32 Hendricks	☐ 46 LaPorte	☐ 60 Owen	☐ 74 Spencer	☐ 88 Washington
☐ 05 Blackford	☐ 19 Dubois	☐ 33 Henry	☐ 47 Lawrence	☐ 61 Parke	☐ 75 Starke	☐ 89 Wayne
☐ 06 Boone	☐ 20 Elkhart	☐ 34 Howard	☐ 48 Madison	☐ 62 Perry	☐ 76 Steuben	☐ 90 Wells
☐ 07 Brown	☐ 21 Fayette	☐ 35 Huntington	☐ 49 Marion	☐ 63 Pike	☐ 77 Sullivan	☐ 91 White
☐ 08 Carroll	☐ 22 Floyd	☐ 36 Jackson	☐ 50 Marshall	☐ 64 Porter	☐ 78 Switzerland	☐ 92 Whitley
☐ 09 Cass	☐ 23 Fountain	☐ 37 Jasper	☐ 51 Martin	☐ 65 Posey	☐ 79 Tippecanoe	
☐ 10 Clark	☐ 24 Franklin	☐ 38 Jay	☐ 52 Miami	☐ 66 Pulaski	☐ 80 Tipton	
☐ 11 Clay	☐ 25 Fulton	☐ 39 Jefferson	☐ 53 Monroe	☐ 67 Putnam	☐ 81 Union	
☐ 12 Clinton	☐ 26 Gibson	☐ 40 Jennings	☐ 54 Montgomery	☐ 68 Randolph	☐ 82 Vanderburgh	☐ State Wide
☐ 13 Crawford	☐ 27 Grant	☐ 41 Johnson	☐ 55 Morgan	☐ 69 Ripley	☐ 83 Vermillion	
☐ 14 Daviess	☐ 28 Greene	☐ 42 Knox	☐ 56 Newton	☐ 70 Rush	☐ 84 Vigo	

Please attach the following documents:
- ☐ 1. W-9 Tax Identification Number
- ☐ 2. Secretary of State letter of authorization to conduct business in Indiana ***(agencies only)***
- ☐ 3. Verification of liability insurance as required by 455 IAC 2-6-2, 455 IAC 2-12-1(4) (vehicle insurance), and 455 IAC 2-11-1 (property and personal Liability insurance)
- ☐ 4. Organizational Chart ***(agencies only)***
- ☐ 5. Copy of Home Health Aide Agency License or Personal Services Agency License ***(if applicable)***
- ☐ 6. All required documents as specified in the provider requirements table located at http://www.in.gov/fssa/da/3476.htm#jump_provider

Have you read the following documents?
- ☐ 1. DA HCBS Waiver Provider Manual: http://provider.indianamedicaid.com/general-provider-services/manuals.aspx ☐ Yes ☐ No
- ☐ 2. The Aging Rule: http://www.in.gov/legislative/iac/T04550/A00020.PDF ☐ Yes ☐ No

Signature of authorized representative

Date *(month, day, year)*

Typed or printed name of authorized representative

Title